VSH Futures
Care Management Work Group

October 13, 2006
Minutes
Revised 11-13-06

Participants: Vic Martini, UCS; Graham Parker, HCRS; Paul Landerl, HCHS; Richard Lanza, LCMH; Anne Donahue, VPS; Peter Thomashow, CVMC; Bob Jimmerson, CSAC; Peter Albert, Retreat Healthcare; Isabelle Dejardins, FAHC/UVM; Stan Baker, HCHS/DS; Michael Hartman, WCMH; Pat Frawley, VCIN, DS; Nick Emlen, VT Council; Stuart Graves, WCMH/NKHS; Jeff Rothenberg, CMC; John Stewart, RMHS; Sandy Steingard, HCHS; Steve Broer, NCSS

Chair: Bob Pierattini, FAHC/UVM

Staff: Beth Tanzman, Bill McMains, Patti Barlow, Judy Rosenstreich, Frank Reed, Cindy Thomas

VSH CENSUS PRESSURES

Bill outlined the current census management strategy:

- At census of 50, DMH notifies Designated Hospitals (DH) and Designated Agencies (DA).
- At census of 52, VSH identifies 2 patients at lowest risk who could be moved on a temporary or permanent basis and involves the identified receiving site in the planning.
- At census of 54, VSH coordinates the movement of the identified patients to the site planned.

Although it is not ideal to move patients, it is important to identify those who are most able to be moved to an alternative site that would best accommodate their needs. The goal is to always have beds available at VSH, especially at night and on weekends, and this goal has not been met recently. There are no transfers in the middle of the night as they would be too disruptive to the patient and others. There are some issues with this strategy including the time it takes to arrange and make these transfers. Also, this is not an ideal system and we will be looking for other ways to increase collaboration between resources, enhance planning and decrease the time involved.

Isabelle noted that FAHC tries to keep 3 beds available but is also feeling the pressure of the VSH census and the difficulty of finding nursing home placements. Anne stated that the Futures Plan assumes that beds made available as a result of implementation of Second Spring would not be filled. Questions were asked about the impact of the reduction of beds at Windham Center (Springfield Hospital) and Rutland Regional Medical Center (RRMC). Peter indicated that often there are beds available in the system but not at VSH, and VSH plays a unique role within the system. Bill observed that the

long term patient cohort is growing the fastest at VSH, therefore, opening up resources in the long term care area may open up more resources at VSH. Stuart offered that it is important not only to focus on admission criteria but also discharge criteria. We need to be able to move people down levels of care. Also, the inpatient programs and outpatient programs currently 'march to a different drummer' and they need to become part of the system of managing census statewide and be able to accept people more rapidly. This has personnel and resource implications. Sandy shared the experience with a current client for whom the pre-placement system would have been helpful. Michael observed that it may be more "surge capability" than simply 'surge capacity'. He also questioned whether or not we really have a clear diagnosis of what the problem is in the system right now and what has changed. Years ago, WCMH placed 25-30 clients a month at VSH. VSH has changed its role to treatment of only the most acute and may not have enough capability for long term care, e.g. working with someone for 6-18 months. Tom stated that subgroups of the long term care population include:

- people who would be appropriate for nursing homes;
- people awaiting non-emergency medications; and
- people who need residential services but cannot rapidly be admitted to residential programs.

Bill shared VSH statistics indicating that admissions to VSH have not actually increased; however, the number of days in the last 3 years for which VSH has had over 50 patients has steadily increased. Richard and Jeff both observed that we have not added new residential beds in nearly 10 years, and that the staffing patterns at these programs have not increased to reflect the clinical needs of the current residential programs. Nick observed that it is very important that we have this discussion together as a system. Peter asked that we consider not closing the beds behind Second Spring clients to other admissions to VSH. Anne expressed that there has been no 'explosion' of emergency exam (EE) admissions, but a gradual and steady increase without an increase in a saturated community capacity, thereby impacting VSH.

SECOND SPRING

Michael provided an update on the program. He stated that a contract has been negotiated and it is in process to be signed. Renovations will begin November 18th and will take 90 to 120 days to complete. A Clinical Steering Committee has been formed to help make the functions and boundaries between Brooks Rehab at VSH and Second Spring as seamless and continuous as possible. A referral process will be established for transition from Brooks Rehab and Second Spring that is clinically sound. This may involve some Second Spring staff spending time at VSH and participating in treatment plan meetings. The program director position is under recruitment, as is the medical director position. Tom emphasized the need for an integrated system between VSH and Second Spring, including bridge programming. Bill added that this is a learning process and, moving forward, there must be ways to adjust the process. Second Spring will need to be able to fluidly serve people from the acute units who have stabilized enough to be ready for rehab, but are not yet ready for typical community placements. Richard asked at what

point will the local DA be involved in the treatment planning for referral to Second Spring and, ultimately, discharge from Second Spring. Michael emphasized that this needs to happen at the very beginning of admissions to Second Spring.

Peter asked about residents' legal status at Second Spring. Participation is voluntary so residents may be on pre-placement status or orders of non-hospitalization, and will be discharged from VSH. Another question asked was how many people have been identified who can be discharged to Second Spring who are on court ordered medication and will take medication voluntarily. Tom indicated that those numbers are not clear yet. WCMHS and NKHS have assessed the VSH population at several different times to evaluate who may have been appropriate and willing to go, and there have generally been about 6 to 9 people. Michael believes that we can use existing structures to support people in treatment. In FY 2006 of 215 admissions, only 15 people went through the non-emergency involuntary medications process, so this is a relatively rare circumstance. Bob likes the conceptualization of Second Spring and Brooks Rehab staff working closely together. He encouraged examination of a range of other options, including individual wraparounds. Michael agreed and felt that the overall goal of moving the locus of this rehabilitation care from the hospital to the community will engage more of the kind of creative, individualized care that is done well in the community, including the use of designated home providers and staffed apartments.

CARE MANAGEMENT RFP

Beth reported that there are resources in this year's budget for care management. She indicated that the conceptual work has been going well, but the lack of people to do more design and development is slowing progress. She suggested that existing funding be used to create a contract through the RFP process that would engage consultants to assist in the design and development of a care management system. She reviewed some core concepts such as the need to:

- Design an information system that will support the care management system (what is out there, what is the cost) as we can define the functionality but do not know what that framework might look like.
- Develop clinical infrastructure to include utilization review, quality assurance and clinical protocols to actualize the principles we have created..

The RFP could also include assessing pressure points across the system and suggesting designs that would work to help better manage issues in the future.

Bob pointed out that we need a way to collect data and look at it logically, such as determining the scope of nursing home needs from the entire system and not just at VSH. Richard asked about the scope of the care management system, specifically, where does movement through the system stop? Bob suggested that the entire spectrum of care is under the purview of the Futures Project such as DOC, private therapists, etc. System boundaries would include all the people with severe mental illness who rely on publicly funded services.

Bill expressed the need soon for an information system that can track in real time the information from all parts of the system and that can be accessed by screeners, hospitals, etc., and asked what it would take given existing capacity. Stan stated there is a need for more long term placements. Peter Albert warned not to neglect support and training required to keep an IT system useful and dynamic for a workforce that may not have extensive computer experience. This needs to be built into the budget, and the care management process could actually lead the blueprint. The question was asked about what the boundaries will be with general health care and also within the private practice sector, in which it would be possible to divert people from chronic care.
Graham observed that the ultimate issue of saturation may be housing and expressed concern about placement issues that exist in the community currently.

Michael suggested that sequencing the clinical work first is needed, to be followed by complementary IT development. Bob offered the reverse; get the data through creating a system that could generate the data. There is a need to know who is in the system at each level of care, and based on this, what is it that they need. A question was posed about whether there are information systems that do this and what it would take to get them running and populated, e.g. that could tell us who/what people need at each level in the system in order to assess the total need for nursing homes. Stan listed several potential stressors in asking about why we are experiencing "exploding numbers", such as what is happening socially and culturally.

Michael expressed concern about privatizing the Futures committee's work, emphasizing that it is important not to replicate the work that has already been done. Bob stated that RFP's should be developed to create a system that will generate data and bring it back to this committee. Jeff stated that people in corrections with severe mental illness should be counted since they may be transferred to the community or hospitals for treatment.

NEXT meeting: November 17th in Waterbury (Stanley Hall 100) from 9-11 am.